MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C1275

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County

City or town Magothy - Pasadena, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Pasadena Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary E Alexander

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John Gordon Alexander

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Dec. 1889

8. AGE: Years 57 | Months 2 | Days | If less than one day hrs. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Wm P Fannon

13. Birthplace Baltimore

MOTHER 14. Maiden name Frances M. Dolan

15. Birthplace Baltimore

16. Informant Frances Fannon

Address 3935 Cloverhill Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 12, 1947 (month) (day) (year)

Cemetery or crematory Cathedral

Location Baltimore

18. Funeral director Rita Wiedefeld

Address 900 East Biddle St

19. 2-11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1947 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8th to Feb 8th 1947, and that I last saw h- alive on Feb 8th 1947

Immediate cause of death	DURATION
Massive Cerebral Hemorrhage	2 hours
Due to Chronic Interstitial Nephritis	several months
Due to E. Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

20 operations

20 autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John G Alexander M. D. or other

Address Glen Burnie Date signed 2/8/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (102)

CERTIFICATE OF DEATH

C1276

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Glen Burnie.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One month
Hospital, Institution, or street address where death occurred:
107-V-ave S.E.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Harry Thomas Bissette

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of ~~husband or~~ wife: Marion Hamilton
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): aug-19-1891

8. AGE:

Years	Months	Days	If less than one day
55	6	15	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Tool Dresser
11. Industry or business

FATHER
12. Name: Thomas Bissette.
13. Birthplace: ?

MOTHER
14. Maiden name: Nancy Kitchen
15. Birthplace: Virginia.

16. Informant: Mrs. H.T. Bissette, (wife)
Address: Glen Burnie Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-5-47 (month) (day) (year)
Cemetery or crematory
Location: Ritchie Md
18. Funeral director: [illegible] Funeral Home
Address: Bethesda Md

19. Feb. 5 1947 (Date rec'd by registrar) McDaniel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February-4 1947, at 11.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19... to ——— 19...
and that I last saw h... alive on — 19...

Immediate cause of death	DURATION
Acute circulatory disease	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: NO Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury Injured at work?

23. SIGNATURE: Gustave A. Faucherd M.D.
Address: Glen Burnie, Md. Date signed: 2/5/47

1-35

Evidence for the change of age is shown on S.109 - 3/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

★ 01277

Reg. Diat. No. 280

1. PLACE OF DEATH

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 5 months

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 years 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residenee of mother)

State: Maryland County: Prince George's

City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)

Street No. 402 Allison
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

Blake - Cornelia

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Samuels - Edward

6.(c) If alive, give age ...? years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day
~~85~~ 27	?	?	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: ?

11. Industry or business: ?

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: Lillian ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/20/47 (month) (day) (year)

Cemetery or crematory

Location: Ft Gaschs Sons Ty attsville, Md

18. Funeral director: Ty attsville, Md.
Address

19. 2/22, 47 (Date rec'd by registrar) E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 1947 at 4:45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9 1944, to February 20 1947 and that I last saw her alive on February 19 1947

Immediate cause of death	DURATION
Lung Tuberculosis	Known to us since 9/19/45
Due to	
Due to	
Other conditions: Dementia Praecox (Schizophrenia) Known to us since 9/19/44	

(Include pregnaney within 3 months of death)

Major findings of operatioos ... Date of op.

Aotopsy results

PHYSICIAN: Please uoderline the caose to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Herbert J. Proctor M. D. or other

Address: Crownsville, Maryland Date signed 2/20/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (139-C)

Registered No. 01278

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Emergency Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Eastport
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Fourth Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elenor Bonnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband ~~or wife~~ Leo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
25	2	21	hr. min.

9. Birthplace South Portland, Maine
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack Willett
13. Birthplace Gardner, Maine

MOTHER
14. Maiden Name Alice McNamara
15. Birthplace Pittsfield, Maine

16 (a) Informant Jack Willett
(b) Address 512 4th Street Eastport

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4 47 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Annapolis Md

18 (a) Funeral director John M. Taylor Son
(b) Address Annapolis Md.

19 (a) Feb 4 47 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1947, at 6:10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pending

Acute endometritis (necrotic).

Due to Cause?

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 2-3-47

VS 151

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01279

Reg. Dist. No. 2B1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

201 Crain Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 201 Crain Highway

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: BERTHA BORKMANN

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Borkmann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 27, 1870

8. AGE:

Years	Months	Days	If less than one day
76	8	12	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER

12. Name: John Rep

13. Birthplace: Germany

MOTHER

14. Maiden name: Unknown Unknown

15. Birthplace: Germany

16. Informant: Matilda Warner

Address: 201 Crain Highway

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 12 1947 (month) (day) (year)

Cemetery or crematory: Sqwartas

Location: 611 S. Donnell St

18. Funeral director: Wm Cook Inc

Address: 247 St. Paul St.

19. 2(10 47) (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEBRUARY 9 1947 at 5:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEB 7 1947, to FEB 9 1947 and that I last saw h.. alive on FEB 9 1947

Immediate cause of death	DURATION
ACUTE CARDIAC FAILURE	
Due to (b) BRONCHOPNEUMONIA	one weeks.
due to (c)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry F Jungen M. D.

M. D. or other

Address: Glen Burnie Md. Date signed Feb 9, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01280 P

(53)

Reg. Dist. No. 2-10

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis, Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infanta give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Washington St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Susanna Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife Matthew Brown

6.(c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1873

8. AGE: Years	Months	Days	If less than one day
73	2	7	hrs. min.

9. Birthplace Anne Arundel County (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Sam Kent

FATHER 13. Birthplace Anne Arundel County

MOTHER 14. Maiden name Eliza Thomas

MOTHER 15. Birthplace Anne Arundel County

16. Informant Mrs. Perdella Brown

Address 108 Washington St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 (month) 5 (day) 47 (year)

Cemetery or crematory Brewer Hill

Location Rest St Annapolis, Md.

18. Funeral director Charles G. Law

Address 802 Madison ave.

19. 2-4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 19 47 at 8.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 19 to Feb 2 19 47 and that I last saw h alive on Feb 2 19 47

Immediate cause of death	DURATION
Carcinoma of skin of L. arm	2 yrs.
Due to Unknown.	
Due to	
Other conditions Sen. Metastases to chest (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. F. Klaware, M.D. / M. D. or other

Address 31 Smithgate ave. Date signed 2/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01281

Reg. Diat. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 113 Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel F. Cantler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katie Cantler
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug 18th 1868

8. AGE: Years	Months	Days	If less than one day
78	6	0	..... hrs. ..... min.

9. Birthplace: Annapolis Md (Town, county, and state)
10. Usual occupation: Ret. Fireman
11. Industry or business: U.S. Naval Exp. Station

FATHER
12. Name: David R. Cantler
13. Birthplace: Harford Co Md.

MOTHER
14. Maiden name: Elizabeth E. Bassford
15. Birthplace: Harford Co. Md.

16. Informant: David Cantler
Address: Eastport A.A.C. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21st 1947 (month) (day) (year)
Cemetery or crematory: Burial
Location: Cedar Bluff Cem't Annapolis
18. Funeral director: John W. Taylor. Son
Address: Annapolis Md.

19. Feb 20 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19 1947, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Feb 1947
and that I last saw him alive on Feb 17 1947

Immediate cause of death	DURATION
Myocarditis & Myocardial Insufficiency	Several years
Due to	
Due to	
Other conditions: Cerebro Sclerosis	Several years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: George C Boyd M. D. or other
Address: Annapolis Md Date signed 2.19.47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35-

Evidence for change of age shown on G 109 - 3/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01282

Reg. Diat. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Mill Creek (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Mill Creek (If outside city or town limits, write RURAL and give nearest town)

Street No.: Brown's Woods (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Vronica C. Cantler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Albert Cantler

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4, 1872

8. AGE: Years	Months	Days	If less than one day
74	11	17	hrs. min.

9. Birthplace: Canada (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Joseph Salaury; 13. Birthplace: Canada

MOTHER — 14. Maiden name: Barbra Brebaker; 15. Birthplace: Canada

16. Informant: Mrs. Mabel Patterson

Address: Mill Creek, Aa Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-24-47 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis, Maryland

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. Feb. 24 1947 (Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 21st 1947, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1946, to Feb 21st 1947

and that I last saw her alive on Feb 15 1947

Immediate cause of death: (a) Myocardial (clot) — DURATION: unknown

Myocardial Infarction

Due to: (b) Arteriosclerosis — DURATION: unknown

Due to: (c)

Other conditions: Chr. Nephritis — DURATION: unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C Bond M. D. or other

Address: Annapolis Md Date signed: 2-23-47

1-3.5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a ★ C1283

CERTIFICATE OF DEATH

Reg. Dist. No. 21C

1. PLACE OF DEATH:

County A.A.

City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Hours

Hospital, Institution, or street address where death occurred:
Masons Boat Yard Severn Ave Eastport, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 321 First Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Wallace Carson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Margaret G. Carson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 13 1895

8. AGE:	Years	Months	Days	If less than one day
52	51	10	27	..... hrs. ..... min.

9. Birthplace Shadyside, Maryland.
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

FATHER 12. Name Charles H. Carson

FATHER 13. Birthplace Maryland.

MOTHER 14. Maiden name Susie A. Bullen

MOTHER 15. Birthplace Maryland

16. Informant Susie A. Brashears

Address Mayo. Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14 1947 (month) (day) (year)

Cemetery or crematory National

Location Annapolis, Md.

18. Funeral director B.L. Hopping & Son

Address Annapolis, Md.

19. Feb. 14 1947 (Date rec'd by registrar) W. P. Dorsch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1947 at 4 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Feb 10 1947 and that I last saw h.. alive on Feb 10 1947

Immediate cause of death	DURATION
Cancer of Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Eastport Date signed 2/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 01284 2/0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS (A15) 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Bay Ridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Bay Ridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lake Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3. (a) FULL NAME: Henry S. Coffin Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Sarah E. Coffin
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 4th 1871

8. AGE:	Years	Months	Days	If less than one day
	75	11	17	..... hrs. ..... min.

9. Birthplace: Eastport Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Carpenter Mate 3rd C Ret.
12. Name of father: Henry S. Coffin
13. Birthplace of father: Md
14. Maiden name of mother: Unknown
15. Birthplace of mother: Unknown
16. Informant: Mrs James Walters
Address: Eastport Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 25th 1947 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: Annapolis Md
18. Funeral director: John M Taylor Son
Address: Annapolis Md
19. Feb. 24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 20, 1947, at No Known M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination
~~and that I last saw him alive on~~ Feby. 21, 1947

Immediate cause of death	DURATION
Hemorrhage (gastric)	sudden
Due to: Carcinoma of Stomach	uncertain
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffy, M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 2/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-a)

CERTIFICATE OF DEATH

01285

Reg. Diat. No. 280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A.A.
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? I2Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie Mewburn Donaldson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Caleb E. Donaldson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 28 I856

8. AGE: Years	Months	Days	If less than one day
90	I	25	..... hrs. ..... min.

9. Birthplace: Odenton (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Philip Mewburn
13. Birthplace: Odenton

MOTHER
14. Maiden name: Julia Warfield
15. Birthplace: Odenton

16. Informant: Wyle Lee Donaldson
Address: Odenton Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 25 I9/7 (month) (day) (year)
Cemetery or crematory: Waugh Chapel
Location: Odeton. Maryland

18. Funeral director: B.L.Hopping & Son
Address: Annapolis, Maryland

19. 2/24 19 47 (Date rec'd by registrar) E.F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 22, 1947, at 11 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby. 16 1947 to Feby. 21 1947
and that I last saw her alive on Feby 21 1947

	DURATION
Immediate cause of death:	
Lobar pneumonia	
Due to: and Pleurisy	6 days
Influenzal type	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Lafferty M.D. M. D. or other
Address: Annapolis Md. Date signed 2-24-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01286 — 71

Reg. Dist. No.

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Riviera Beach, P.O. Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred: Church Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A-A
City or town: Riviera Beach, P.O. Pasadena
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Church Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Louise Eichner

3.(b) Social Security Number: 214-18-3585

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband ~~or wife~~: Matthew Eichner.
6.(c) If alive, give age: Dead. years

7. Birth date of deceased (mo., day, yr.): Dec. 2nd 1884

8. AGE:

Years	Months	Days	If less than one day
62	2	22	....hrs. ....min.

9. Birthplace: Nuremberg, Germany.
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business

FATHER
12. Name: ~~Unknown~~ Palzer
13. Birthplace: Germany.

MOTHER
14. Maiden name: Unknown.
15. Birthplace

16. Informant: Mrs. Emil Eichner (Son)
Address: Riviera Beach, P.O. Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27/47 (month) (day) (year)
Cemetery or crematory: Western
Location: Baltimore, Md.
18. Funeral director: F. J. Wippel & Son
Address: 850 W. Baltimore St.

19. 2/26/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 1947 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Cerebral Hemorrhage	sudden.
Due to: Hypertension	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave A. Faupel M.D.
Assistant Deputy Medical Examiner M. D. or other
Address: Glen Burnie, Md. Date signed 2/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

01287

Reg. Dist. No. 2-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. - MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Revera Beach, P.O. Pasadena.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years.
Hospital, institution, or street address where death occurred: Ashbury Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Revera Beach, P.O Pasadena.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Ashbury Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Annie E. Ford.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband or wife: John Ford.
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): December 12 - 1886

8. AGE: Years	Months	Days	If less than one day
56	2	3	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Franklin Knapp
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden name: Catherine Easter
15. Birthplace: Baltimore, Md.

16. Informant: Wm. John Ford (husband)
Address: Revera Beach. P.O. Pasadena.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 17, 1943 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: 3930 Frederick Ave
18. Funeral director: Harry F. Wiltse
Address: 401 Edmondson Ave
19. 2-17-43 (Date rec'd by registrar) 19 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 19 43, at 5:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Hypertension and cardio-vascular disease	sudden
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustav H. Fraudenthal M.D.
M. D. or other
Address: Glen Burnie Md. Date signed: 2/15/43

gk 1500

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(117) 01288 P.

Reg. Dist. No. 226

1. PLACE OF DEATH: A. A. Co.

County ....

City or town .... Jessup

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .... 10 yrs.

Hospital, institution, or street address where death occurred ....

How long in hospital or institution? ....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State .... Md. County .... A. A. Co.

City or town .... Jessup

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war ....

3.(a) FULL NAME Arthur F. Forecare

3.(b) Social Security Number 218-05-4251

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married.

6.(b) Name of husband or wife .... Alethea E. Forecare

6.(c) If alive, give age .... 52 years

7. Birth date of deceased (mo., day, yr.) .... July 11th. 1886

8. AGE: Years 60 Months 7 Days 13 If less than one day .... hrs. .... min.

9. Birthplace .... Balto. City, Md. (Town, county, and state)

10. Usual occupation .... Quarter-man

11. Industry or business .... Sheet Metal Works.

FATHER 12. Name .... Thos. J. Forecare

13. Birthplace .... Balto. City, Md.

MOTHER 14. Maiden name .... Anna Schuld

15. Birthplace .... Balto. City, Md.

16. Informant .... Mrs. Arthur F. Forecare

Address .... Jessup, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2/27/47 (month) (day) (year)

Cemetery or crematory .... Lorraine Cem.

Location .... Balto. City, Md.

18. Funeral director .... Mrs. J. Ambrose

Address .... 414 Shamrock Rd. Balto. City, Md.

19. 2/25 19 47 (Date rec'd by registrar) .... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH .... Feb. 24th. 1947 at 6.25 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 1st. 1946 to Feb. 24th 1947 and that I last saw h.. alive on Feb. 24th 1947

Immediate cause of death	Myocardial Insuff.	1 wk.
Due to	Asthma	10 yrs.
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE .... Frank Shipley, M.D. M. D. or other

Address .... Savage, Md. Date signed 2/25/47

I-50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

* 01289

Reg. Diat. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: Enrout to Doctors Office
How long in hospital or institution? -- -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 36 Clay Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clement Green Jr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	-- ------

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 23, 1946

8. AGE: Years	Months	Days	If less than one day
0	2	13	..... hrs. ..... min.

9. Birthplace: Annapolis Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Clement Green
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden name: Barbara Butler
15. Birthplace: Annapolis Maryland

16. Informant: Barbara Butler
Address: 36 Clay Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 11, 1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Feb 11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 10 1947, at 11 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1 1947, to 2-10 1947
and that I last saw him alive on 2-3- 1947

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: G T Talley M.D.
Address: 17 Carroll St M. D. or other
Date signed 2-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01290 C

(47c) * 270

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundle

City or town: Green Haven (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundle

City or town: Green Haven (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Frederick W. Gross

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ann Elizabeth

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8 - 12 - 1892

8. AGE:

Years	Months	Days	If less than one day
54	6	1	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Trader

11. Industry or business: Ice

FATHER 12. Name: Unkown

13. Birthplace

MOTHER 14. Maiden name: Unkown

15. Birthplace

16. Informant: Ann Elizabeth Gross (wife)

Address: Green Haven

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-17-1947 (month) (day) (year)

Cemetery or crematory: Glenn Dawes

Location: Ritchie Highway

18. Funeral director: Tilly & Zeiler Inc.

Address: 403 S. Wolfe Street

19. 2/17 19 47 (Date rec'd by registrar) Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13 1947, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/15 1946, to 2/13 1947

and that I last saw h.../M alive on 2/13 1947

Immediate cause of death	DURATION
Heart Failure	
Due to: Hypertensive Cardio-Vascular Disease	5 yrs
Due to:	
Other conditions: Bronchogenic Carcinoma	?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Brady Smith M.D. M. D. or other

Address: Riviera Beach Date signed: 2/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-6)

CERTIFICATE OF DEATH

01291

DC Reg. Dist. No. 280

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 4 mos. 24 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 3 yrs. 4 mos. 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1610 N. Gilmer St.

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME Enoch F. H arding

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Clara Harding

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
50	?	?	...hrs. ...min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business ?

FATHER 12. Name Nathaniel Harding

13. Birthplace Maryland

MOTHER 14. Maiden name Lillian Trusley

15. Birthplace Maryland

16. Informant Hospital Records, Crownsville State Hospital, Crownsville, Maryland

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27/47 (month) (day) (year)

Cemetery or crematory Hospital

Location Crownsville

18. Funeral director Supt.

Address Crownsville

19. 2/27/47 (Date rec'd by registrar) E.T. Jay Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1947 at 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1943 to February 13 1947

and that I last saw him alive on February 13 1947

	DURATION
Immediate cause of death General Paresis	Known to us since Sept. 20, 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert J. Winkfoot M. D. or other

Address Crownsville, Maryland Date signed 2/13/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(93) 01292

Reg. Dist. No. 230

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M.

1. PLACE OF DEATH:

County Anne Arundel

City or town Dorsey (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Dorsey md (If outside city or town limits, write RURAL and give nearest town)

Street No. ff. Rural Rd (If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME Chester Allen Hare

3. (b) Social Security Number 213-10-0703

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Grace Naomi Stephenbotham Hare

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Oct 22 1897

8. AGE: Years 59 Months 3 Days 29 If less than one day ..... hrs. ..... min.

9. Birthplace Union North Carolina (town, county, and state)

10. Usual occupation Mechanic

11. Industry or business Balto Transit (Retired)

FATHER 12. Name Blackman Hare

FATHER 13. Birthplace unknown

MOTHER 14. Maiden name Nellie Brent

MOTHER 15. Birthplace unknown

16. Informant Mrs Grace N. Hare (wife)

Address Dorsey Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/24/47 (month) (day) (year)

Cemetery or crematory Baltimore

Location E North Ave

18. Funeral director Edward Foulson

Address 2359 Wash Blvd

19. 2/21 1947 (Date rec'd by registrar) Registrar

I-03

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1947, at 1 8 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943, to Feb 20 1947 and that I last saw h... alive on Feb 18 1947

22. Immediate cause of death Acute Dilatation of heart — DURATION 1 da

Due to Myocardial Insufficiency — 2 yrs

Due to Arteriosclerotic Hypertension — 7 yrs

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE G. B. Brumbaugh M. D. or other

Address Elkridge Md Date signed 2/20/47

Mr J B Hare

Route 2

Faison N C

Allen Yon Brothers

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01293

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since July 8, 1946.
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? since July 8, 46.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brownswoods, Md. FDR # 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Box 381.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EARL STANLEY HAROLD.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9 - 5 - 33.

8. AGE: 13 Years | Months 4 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace: Brownswoods, Md.
(Town, county, and state)

10. Usual occupation: -

11. Industry or business

FATHER 12. Name: Dennis Harold, deceased,
13. Birthplace: Norfolk, Va.

MOTHER 14. Maiden name: Lena Harold,
15. Birthplace: Mulberry, Md.

16. Informant: Lena Harold, mother, and Hospital records,
Address: of Crownsville State Hospital.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5-47 (month) (day) (year)

Cemetery or crematory: Broadneck

Location: Broadneck, Md

18. Funeral director: J. B. Johnson

Address: Annapolis, Md

19. 2-3 (Date rec'd by registrar) 1947 E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Febr. 2 19 47, at 1,15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem examination 19 ....
and that I last saw ... alive on ... Febr. 2 19 47

Immediate cause of death: Second and third burns all over body except head from emersion in bath
Due to: of scalding water.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: accidental 2-2-47
Accident, suicide, or homicide: Date of
Where did injury occur? Crownsville (City or town) AA. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Crownsville State Hospital.
Means of injury: Scalds. Injured at work? No

23. SIGNATURE: John M. Clapp M.D. Deputy Medical Examiner
M. D. or Coroner
Address: Annapolis Md Date signed: 2-2-47

1-35

01294

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:

County: Anne Aru del Co.

City or town: Eastport Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, institution, or street address where death occurred: 418 First St.

How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: East Port Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 418 First St
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Louis Harris

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Arneitha Harris

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): December 23, 1883

8. AGE: Years	Months	Days	If less than one day
63			...hrs. ...min.

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: Benjamine Harris
13. Birthplace: A. A. Co.

MOTHER
14. Maiden name: Sara Read
15. Birthplace: A. A. Co. Md.

16. Informant: Mrs Arneitha Harris
Address: 418 First St. East Port Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-15-47 (month) (day) (year)

Cemetery or crematory: Brewer Hill Cemetery

Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. Feb 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13, 1947, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1945, to February 13 1947 and that I last saw h.. alive on February 13 1947

Immediate cause of death: Acute Myocarditis

DURATION
2 yrs

Due to:

Due to:

Other conditions: Arterial Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: R. B. Richardson M.D. M. D. or other

Address: Riva, Md. Date signed 2/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C1295

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Hardlette Court (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William H. Hawkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	widower

6.(b) Name of husband or wife: Hattie Hawkins
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11 1868

8. AGE: Years	Months	Days	If less than one day
78	8	12	..... hrs. ..... min.

9. Birthplace: Calvert Co. (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business
FATHER 12. Name: Isaac Henry Hawkins
13. Birthplace
MOTHER 14. Maiden name: Louise Hunt
15. Birthplace: Md
16. Informant: Isaac Hawkins
Address: 901 S. 18th Phila. 46 Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 27 1947 (month) (day) (year)
Cemetery or crematory: Chewn
Location: Owensville
18. Funeral director: J. B. Lyon
Address: Annapolis
19. Feb. 27 1947 (Date rec'd by registrar) C. Arnold Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23. 1947, at 10 05 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 17 1947, to Feb 23 1947
and that I last saw h[illegible] alive on Feb 23 1947

Immediate cause of death	DURATION
Coma Cerebrovascular	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. T. Alby M. D. or other
Address: 17 Conduit Date signed: 2-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ind correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) ~~Baltimore City~~, Maryland
(b) Street address
(c) Hospital or institution: Nabbs Creek, Glen Burnie, R.D.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Nabbs Creek
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marjorie L. Hillary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William G. Hillary
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1895

8. AGE: Years	Months	Days	If less than one day
51	2	4	hr. min.

9. Birthplace Martinsburg, West Virginia
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name John J. Bready
13. Birthplace Morgan Co. W. Va.

MOTHER
14. Maiden Name Florence V. Hoyle
15. Birthplace Hagerstown, Md.

16 (a) Informant Donald Rosales, Jr.
(b) Address Manhattan Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10 1947 (month) (day) (year)
Severna P.O.
(c) Cemetery or crematory Louden Park
Location Baltimore, Md.

18 (a) Funeral director Thomas W. Pinglatow
(b) Address Glen Burnie, Md.

19 (a) Feb. 8-1947 (Date rec'd by registrar) (b) Mae Allen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1947, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia
Hypertension and dilatation of heart
Fatty liver; Nephrosclerosis
~~Due to~~ Subdural hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-7-47

VS 151

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 01297

Reg. Diat. No. 25

1. PLACE OF DEATH:

County A A County Md.

City or town Brooklyn Hts Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A A Co Md

City or town 217 Doris Ave Brooklyn Hts Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME August Hohenstein

3.(b) Social Security Number 213-01-9493

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife Sadie Joynes Hohenstein

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 2nd 1875

8. AGE:	Years	Months	Days	If less than one day
	72	--	--	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Retired Engineer

11. Industry or business U S Industrial Chemical Co Curtis Bay

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Mrs Sadie Brown (daughter)
Address 217 Doris Ave Brooklyn Hts-25-

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14-47 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Gov Ritchie Highway

18. Funeral director Milton Schilling

Address 3914 Hanover St

19. February 12 1947 (Date rec'd by registrar) Ida M. Hohstein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Fecruary 11th 1947 at 5.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to Feb 11, 1947 and that I last saw him alive on February 10, 1947

Immediate cause of death	DURATION
Chronic Myocarditis	1 yr.
Due to Arteriosclerotic Heart Disease	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. J. Gruinaldi M.D.
M. D. or other

Address 4609 Gov. Ritchie Hway Date signed 2-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-E)

01298

CERTIFICATE OF DEATH

Reg. Dist. No. 250

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 210 Arundel Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Larry George Hooper

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	—

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 2, 1946

8. AGE: Years	Months	Days	If less than one day
	3	11	hrs. min.

9. Birthplace: Baltimor, Maryland
(Town, county, and state)
10. Usual occupation: —
11. Industry or business: infant

FATHER
12. Name: Edwin C. Hooper
13. Birthplace: Baltimor, Md

MOTHER
14. Maiden name: Irine Lorenz
15. Birthplace: Baltimor, Md

16. Informant: Edwin C. Hooper
Address: 210 Arundel Road Brooklyn Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/15/47 (month) (day) (year)
Cemetery or crematory: Holy Cross Brooklyn Md
Location: Gov Ritchie Highway

18. Funeral director: Milton Schilling
Address: 3914 Hanover St - 25 -

19. February 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 13 1947 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination ~~and that I last saw h~~ alive on Feby. 13 1947

Immediate cause of death	DURATION
Due to: Intestinal Grippe	10 days
and Dysentery	5 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John McClafty M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed: 2-13-47

VS A15 9-45-75M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01299

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A. A.

City or town: Burleigh Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Burleigh Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Jeffries

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	colored	widow.

6.(b) Name of husband ~~or wife~~: L. W. Jeffries

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 23, 1879

8. AGE: Years	Months	Days	If less than one day
67			..... hrs. ..... min.

9. Birthplace: Milton N. C. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: Burgat Jones

13. Birthplace: N. C.

MOTHER — 14. Maiden name: Phibe (Unknown)

15. Birthplace: N. C.

16. Informant: Edna Bell

Address: Burleigh Heights

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 2 1947 (month) (day) (year)

Cemetery or crematory: First Baptist Cem.

Location: Burleigh Heights.

18. Funeral director: J. B. Johnson

Address: Adamsboro

19. March 1 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 27 19 47, at 12.03 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 - 47 to Feb 27 - 47 and that I last saw her alive on Feb 26 - 47 19

Immediate cause of death	DURATION
Lobar Pneumonia.	3 days
Due to	
Due to Chronic Nephritis	
Other conditions Hypertension.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Joseph Lipsey M. D. or other

Address: Statesville Date signed: Feb 28 - 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

01300

2411 N. Charles St., Baltimore (93-E)

CERTIFICATE OF DEATH

Reg. Diat. No. 210

1. PLACE OF DEATH:

County Anne Arundel

City or town Rural Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town R. 2 Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Skidmore Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Addie Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1902

8. AGE: Years	Months	Days	If less than one day
44	2	29	..... hrs. ..... min.

9. Birthplace Skidmore A.A. Co. (Town, county, and state)

10. Usual occupation Domestic.

11. Industry or business

FATHER

12. Name Alfred Johnson

13. Birthplace Md.

MOTHER

14. Maiden name Sarah Stevens

15. Birthplace Md.

16. Informant Mattie Wilson

Address R. F. D. 2 Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 2 1943 (month) (day) (year)

Cemetery or crematory Broadneck

Location Skidmore, Md.

18. Funeral director J. B. Johnson

Address Annapolis, Md.

19. March 1, 1947 (Date rec'd by registrar) W. D. Brinch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1947 at 2:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 1947 to Feb 26 1947 and that I last saw h.. alive on Feb 20 1947

Immediate cause of death	DURATION
Congestive heart failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury Injured at work?

23. SIGNATURE A. T. Allen M D

M. D. or other

Address 17 Carroll St. Date signed 2-28-47

It is especially important that physicians please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

★ 01301

Reg. Dist. No. 2/0

1. PLACE OF DEATH:

County A.A.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Years

Hospital, Institution, or street address where death occurred:
I9 Murry Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

Street No. I9 Murry Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Moses Katcef

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widow

6.(b) Name of husband or wife Sarah Katcef

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct IO I870

8. AGE: Years	Months	Days	If less than one day
76	4	9	..... hrs. ..... min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual occupation TRader

11. Industry or business

FATHER
12. Name Philiph Katcef
13. Birthplace Lithuania

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Israel Katcef
Address I9 Murry Ave Annapolis, Md.

17. Burial Date thereof Feb 20 I947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Kneseth Israel
Location Best Gate, Md.

18. Funeral director B.L. Hopping & SOn
Address Annapolis, Md.

19. Feb. 20, 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 19 47 at 11 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July, 19 46, to Feb 18 19 47
and that I last saw him alive on Feb 18 19 47

	DURATION
Immediate cause of death Coronary Thrombosis	3 hrs.
Due to Arterio Sclerosis	Several years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boyd M. D. or other

Address Annapolis Md Date signed 2-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (840)

CERTIFICATE OF DEATH

01302

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: LAUREL Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years - 2 months
Hospital, institution, or street address where death occurred:
DISTRICT TRAINING School
How long in hospital or institution? 4 yr - 2 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ..... County: .....
City or town: WASHINGTON D C
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1640 Massachusetts SE
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME: FRANCIS KIDWELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife: NONE
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 20 - 1935

8. AGE:

Years	Months	Days	If less than one day
11	3	15	..... hrs. ..... min.

9. Birthplace: Washington DC
(Town, county, and state)
10. Usual occupation: NONE
11. Industry or business

FATHER
12. Name: CARLTON L KIDWELL
13. Birthplace: VIRGINIA

MOTHER
14. Maiden name: VERDI A BROWN
15. Birthplace: WASHINGTON DC

16. Informant: RECORDS DISTRICT TRAINING School
Address: LAUREL, Md

17. (Burial, cremation, or removal. Which?) Removal Date thereof Feb 4 1947 (month) (day) (year)

Cemetery or crematory: .....
Location: Washington DC.

18. Funeral director: H. L. Eckenrode's Co
Address: 517-11th St SE Wash. DC.

19. Feby 4 1947 (Date rec'd by registrar) Clara Kasluh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4 1947, at 8 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 1946, to Feb 4 1947
and that I last saw him alive on Feb 3 - '47 1947

Immediate cause of death	DURATION
INANITION	4 mo
Due to:	
Due to:	
Other conditions: MONGOLOID IDIOCY	Life
PYLOROSPASM	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: James Lenwood MD M. D. or other
Address: LAUREL, Md Date signed 2-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

01303

Reg. Diat. No. 21

1. PLACE OF DEATH:
County A.A
City or town Homewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
1100 Maple Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A.A.
City or town Homewood,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1100 Maple Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Adam Kriegbaum

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Anna M. Kriegbaum
6.(c) If alive, give age 91 years

7. Birth date of deceased (mo., day, yr.) Nov 2, 1854

8. AGE: Years	Months	Days	If less than one day
92	3	7	...hrs. ...min.

9. Birthplace Balto, Maryland.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Kriegbaum
13. Birthplace Baltimore, Maryland.

MOTHER 14. Maiden name Catherine Shore
15. Birthplace Baltimore, Maryland.

16. Informant Charles Schlegel
Address 1100 Maple Street, Homewood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 12 1947 (month) (day) (year)
Cemetery or crematory Glen Haven Memorial Park,
Location Glen Burnie, Md.

18. Funeral director B.L. Hopping & Son
Address 172 West STreet. Annapolis, Md.

19. Feb. 11, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10th 1947, at 2 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1946, to Feb 10th 1947
and that I last saw h.kim alive on Feb 9th 1947

Immediate cause of death	DURATION
Myocardial Ins. with Myocardial Insufficiency	1 year.
Due to	
Due to	
Other conditions Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE George C Boyle, M. D. or other
Address Annapolis Md Date signed 2-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

01304

Reg. Dist. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Arnold (Chase Creek)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Pines-on-Severn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 218 Ridgeway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ivan Ross Lamb Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2nd 1933

8. AGE: Years	Months	Days	If less than one day
13	9	26	hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: school
11. Industry or business
FATHER 12. Name: Ivan Ross Lamb Sr.
FATHER 13. Birthplace: Wisconsin
MOTHER 14. Maiden name: Gladys A. Cadle
MOTHER 15. Birthplace: Baltimore Md.
16. Informant: Ivan Ross Lamb Jr
Address: Pines on the Severn Arnold Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 3-1947 (month) (day) (year)
Cemetery or crematory: Glen Haven Memorial Park
Location: Glenburnie Q A & Md
18. Funeral director: Glen M. Taylor
Address: Annapolis Md.
19. March 3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 28, 1947 at 5:20 A.M.
21. I CERTIFY that death occurred on the date above stated: Post Mortem Examination Feby. 28 1947
Immediate cause of death: Drowning — DURATION
Due to: accidental
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 2-28-47
Where did injury occur? Arnold (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Chase Creek
Means of injury: drowning Cooke Inn Injured at work? Statter.

23. SIGNATURE: John M. Clatley M.D. Deputy Medical Examiner (M. D. or Other)
Address: Annapolis, Md. Date signed: 2-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

01305

CERTIFICATE OF DEATH

Reg. Diat. No. 210

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Annapolis Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Forrest Glenn Long

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 24, 1947

8. AGE: Years | Months | Days | If less than one day: 9 hrs. 50 min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Hugh Rutledge Long

FATHER — 13. Birthplace: Lynchburg, Virginia

MOTHER — 14. Maiden name: Frances Elizabeth Mayberry

MOTHER — 15. Birthplace: Campbell County, Virginia

16. Informant: Hugh R. Long

Address: Edgewater a a Co Md

17. Burial, cremation, or removal. Which?: Burial — Date thereof: 7 (month) Feb 28 (day) 1947 (year)

Cemetery or crematory: Asbury

Location: Arnold Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md

19. Feb 26 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Prematurity (Premature birth)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Lucas M.D.
M. D. or other

Address: Queen St Ad

Date signed: 2/24/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 01306 D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a few hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For nonresidents, give usual residence of mother)
State: Maryland County: Kent
City or town: Wyoming
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William H. Maberry.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Bertha M. Mayberry
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Feby. 12. 1877

8. AGE:

Years	Months	Days	If less than one day
70	0	6	..... hrs. ..... min.

9. Birthplace: Hartly Kent Co. Delaware
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: General Farming
FATHER 12. Name: John Maberry
13. Birthplace: unknown.
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: William Thomas Maberry
Address: Edgewater, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 21 1947 (month) (day) (year)
Cemetery or crematory: Lake Side Cemetery
Location: Dover Del.
18. Funeral director: John M. Taylor. Con
Address: Annapolis Md.
19. Feb 20 1947 (Date rec'd by registrar) Edward Bellemy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 18. 1947 at 9 P. M.
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem & Examination
and that I last saw ~~him~~ alive on Feby. 18 1947

Immediate cause of death	DURATION
Acute Dilatation of	
Due to Heart	Sudden
Due to General arterio-sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 2-18-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01307

MV

Reg. Diat. No. 240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Calfornia County:
City or town: Los Angelas
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1271 ½ N. Crescent Heights
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Andrew Jackson McCampbell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: E. Lavalle McCampbell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 27th 1874

8. AGE: Years: 72 Months: 2 Days: 16 If less than one day: hrs. min.

9. Birthplace: South Pittsburg Tenn.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Comdr. David McCampbell U.S.N. (Ret.)
Address: N. Shore Road Algonquin Park Norfolk Va.

17. Cremation
(Burial, cremation, or removal. Which?) Date thereof: Feb 13th 1947 (month) (day) (year)

Cemetery or crematory: Ft Lincoln
Location: Pris. Geo Co. Md.

18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. Feb. 13, 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 12 1947 at 4 40 P M

21. I CERTIFY, that death occurred on the date above stated: Post mortem Examination Feby. 12 1947

	DURATION
Immediate cause of death: Sub. dural Hemorrhage	
Due to: Severe Concussion of brain.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Feby 9 1947
Where did injury occur? Route #50 (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Highway
Means of injury: Auto skidded + turned over Injured at work?: No

23. SIGNATURE: John M. Claffey M.D. Deputy Chief Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: Feby 13 '47

2-35

0130

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Light St Rd - R.F.D. #9

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Brooklyn #25

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #9 Light St Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Pauline A. Metzke

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Theodore Metzke

6.(c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): January 16, 1868

8. AGE: Years: 79 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Julius Dahlke

13. Birthplace: Germany

MOTHER

14. Maiden name: Augusta Meyer

15. Birthplace: Germany

16. Informant: Mrs. Elsie Bailey

Address: R.F.D. #9 - Balto #25

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/1/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Annapolis Blvd.

18. Funeral director: John F. Denny Inc. & Lees

Address: 716 Light St.

19. 3/1/47 (Date rec'd by registrar) 19 A. H. Hedrick per L.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24th 1947 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15- 1947 to Feb 25-47 1947 and that I last saw her alive on Feb 24-47 1947

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to Chronic Nephritis	
Other conditions Cardio Vascular Renal Disease + malignant hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph L. Wolfe M. D. or other

Address: Glenburnie Md Date signed: Feb 28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

01309

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 21 Obrigant alley
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Louis Mobray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
male	colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1867

8. AGE: Years 80 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: a. A. Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: John Mobray
13. Birthplace: Annapolis.

MOTHER
14. Maiden name: Sallie Mobray
15. Birthplace: Md.

16. Informant: Albert Mobray
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 3, 1947 (month) (day) (year)
Cemetery or crematory: Brewers Hill
Location: Annapolis Md.

18. Funeral director: J. B. Johnson
Address: Annapolis Md.

19. March 1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 27, 1947, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1947, to Feb 27, 1947
and that I last saw h... alive on ..... 19....

	DURATION
Immediate cause of death: Apoplexy	2 days.
Due to: Cardio-Hypertensive Vascular Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Clyde W. Johnson M.D.
M. D. or other
Address: 40 Northwest Street. Date signed 2/27/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01898

Reg. Diat. No. 280

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months 24 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 months 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ? County: ?

City or town: ?
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Archie Nichols

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated (?)

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1897 (?)

8. AGE: Years	Months	Days	If less than one day
49 ?	?	?	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Arthur Nichols
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Dora Hightower
15. Birthplace: North Carolina

16. Informant: Hospital Records Crownsville State
Address: Hospital, Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or ~~crematory~~: Hospital Cemetary, Crownsville

Location: Crownsville, Maryland

18. Funeral director: Suitt.

Address: Crownsville Md

19. 2/27/47 E. Joyce Loar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 19 47 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30 1946, to February 24 1947, and that I last saw him alive on February 24 1947.

	DURATION
Immediate cause of death: General Paresis	Known to us since 9/30/46
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Albert J. Blackwood M. D. or other

Address: Crownsville, Maryland Date signed: 2/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35-

01310

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 0

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 77 College Creek Terrace
How long in hospital or institution? ---------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arunde l
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 77 College Creek Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war: ----------

3.(a) FULL NAME: Elenor Elizabeth Oliver

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Charles A. Oliver
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 10, 1883

8. AGE: Years	Months	Days	If less than one day
63	4	10	..... hrs. ..... min.

9. Birthplace: Annapolis Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Louis Queen
13. Birthplace: Anne Arundel Co. Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Charles A. Oliver
Address: 77 College Creek Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/ 23/ 1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43- 45 Northwest Street

19. Feb. 23, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 20 1947, at 6 35 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~xxxxxxxxxx~~ Post mortem Examination ~~xxxxxxxxxx~~ Feby. 20. 1947

	DURATION
Immediate cause of death: Acute Dilatation of Heart	Sudden
Due to: Physical Exertion of a violent coughing spell	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Clatty M.D. Deputy Medical Examiner
Address: Annapolis, Md. Date signed: 2-22-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

01311

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:

County A.A.e.

City or town Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Months

Hospital, institution, or street address where death occurred:
I93 Green Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.e.

City or town Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

Street No. I93 Green
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eugene Melvin Parse

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Alice V. Parse

6.(c) If alive, give age I7 years

7. Birth date of deceased (mo., day, yr.) May 3 I924

8. AGE: Years	Months	Days	If less than one day
22	9	27	....hrs. ....min.

9. Birthplace Terre Haute, Ind.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name William J. Parse

FATHER 13. Birthplace Illinois

MOTHER 14. Maiden name Mary Kelley

MOTHER 15. Birthplace Terre Haute, Ind

16. Informant William J. Parse

Address ROssford, Ohio

17. Removal Date thereof Feb 28 I947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Unknown

Location Rossford, Ohio.

18. Funeral director B.L.Hopping.

Address Annapolis, Maryland.

19. Feb. 28 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby. 27 1947, at 12 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that Postmortem Examination, 19.... Feby. 27 1947

	DURATION
Immediate cause of death	
Suicide by	
Due to hanging.	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 2-27-47

Where did injury occur? Annapolis (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury hanging Injured at work? no

23. SIGNATURE John M. Claffy M.D Deputy medical Examiner
M. D. or other

Address Annapolis, Md. Date signed 2-27-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01312

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Baltimore City A.A. County

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years 1 month 12 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 16 years 1 month 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ?

City or town: ?

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Arthur Queen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of hueband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): – 1910

8. AGE: Yeare	Months	Days	If less than one day
37 (?)	?	?	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and atate)

10. Usual occupation: ?

11. Industry or business: ?

FATHER 12. Name: ?

FATHER 13. Birthplace: ?

MOTHER 14. Maiden name: ?

MOTHER 15. Birthplace: ?

16. Informant: Hospital Records

Address: Crownsville State Hospital, Crownsville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: February 7, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore, Maryland

18. Funeral director: Jesse W. Redden

Address: 436 W. Biddle St. Baltimore, Maryland

19. 2/5 (Date rec'd by registrar) 47 E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 19 47 at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1930, to February 4 1947 and that I last saw him alive on February 3 1947

Immediate cause of death	DURATION
Lung Tuberculosis	
Tuberculous Peritonitis	Known to us 4 wks.
Glandular Tuberculosis	
Due to:	
Due to:	
Other conditions: Psychosis Mental Deficiency	Known to us since April 23,1930

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert V. Amickson M. D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Local # 01313

Reg. Dist. No. 210

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Stoney Run

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Catherine Eleanore Queen.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Black	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): January 14 - 1940

8. AGE:

Years	Months	Days	If less than one day
7	1	10	hrs. min.

9. Birthplace: Glen Burnie Md. (Town, county, and state)

10. Usual occupation: None.

11. Industry or business:

FATHER

12. Name: Thomas B. Queen.

13. Birthplace: Anne Arundel Co. Md.

MOTHER

14. Maiden name: Mary E. Johnson.

15. Birthplace: Harmers, D. C. Co. Md.

16. Informant: Thomas B. Queen - (Father)

Address: Stoney Run, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 1, 1947 (month) (day) (year)

Cemetery or crematory: St. Marks Cem.

Location: A. A. Co. Md.

18. Funeral director: Mrs. Katie P. Williams

Address: 322 W. Lexington St.

19. March 1947 (Date rec'd by registrar) A. H. Aldrich per LW Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28 1947 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27 1947, to Feb. 28 1947 and that I last saw h[illegible] alive on 2/27/47 1947

Immediate cause of death: Marasmus.

Due to: General Debility since birth.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: Since birth

Major findings of operations: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work?

23. SIGNATURE: Gustave A. Pauker M.D. M. D. or other

Address: Glen Burnie, Md. Date signed 2/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

* 01314

Reg. Diat. No. 201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County A. A.
City or town Lothian
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Lothian
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Francis Randall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Colored	Married

6.(b) Name of husband or wife Joseph H. Randall
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4 1909

8. AGE: Years	Months	Days	If less than one day
37	5	13	..... hrs. ..... min.

9. Birthplace Mc Kendree (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name Clarence Blake
FATHER 13. Birthplace A. A. Md.
MOTHER 14. Maiden name Nellie Franklin
MOTHER 15. Birthplace Calvert Co.
16. Informant Joseph Randall
Address Friendship Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 20 1947 (month) (day) (year)
Cemetery or crematory Methodist
Location Friendship
18. Funeral director B. Thyson
Address Owensville
19. Feb. 20 1947 (Date rec'd by registrar) M. Clayton Reg. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1947 at 4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7 1947 to Feb. 7 1947
and that I last saw h... alive on not at all 19...

Immediate cause of death	DURATION
coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Emily H. Watson M.D. M. D. or other
Address Lothian Date signed 2/19/47

2-35

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

01315

CERTIFICATE OF DEATH

Reg. Dist. No. 2/0

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)
Street No. 1019 Tyler Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Edward Rippert
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct 16th 1946

8. AGE: Years — Months 3 — Days 22 — If less than one day ... hrs. ... min.

9. Birthplace: Annapolis Md. (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Frances E. Rippert
13. Birthplace: Madison Kan.

MOTHER
14. Maiden name: Anna M. Meade
15. Birthplace: Annapolis Md.

16. Informant: Frances E. Rippert
Address: 1019 Tyler Ave Eastport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 9th 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven Memorial
Location: Glenburnie A.A. Co. Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. Feb 9, 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 7 1947 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination Feby. 7, 1947

Immediate cause of death — DURATION

Due to: Asphyxiation

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date: Feby. 7, 1947
Where did injury occur? Eastport, A.A., Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: Smothered in crib Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis, Md Date signed: 2/7/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01316

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 516 Second
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Anna Rodgers

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Charles E. Rodgers
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jany 16th 1879
8. AGE: Years: 68 Months: 1 Days: If less than one day: hrs. min.
9. Birthplace: Phila Pa
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: Wm E. Johnson
13. Birthplace: New Jersey
MOTHER 14. Maiden name: Margaret Dingler
15. Birthplace: New Jersey
16. Informant: Mrs Dorothy Williams
Address: Eastport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 19th 1947 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cem
Location: Annapolis Md.
18. Funeral director: John M. Taylor, Son
Address: Annapolis Md.
19. Feb. 18, 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16 1947, at 2 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Feb 16 1947 and that I last saw h[illegible] alive on Feb 16 1947

Immediate cause of death	DURATION
Myocarditis & Myocardial Insufficiency (Chr)	Several years
Due to	
Due to Arteriosclerosis	unknown
Other conditions Chr. Nephritis	Several years.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Grace C Buck
M. D. or other
Address: Annapolis Md. Date signed 2-18-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(108) 01317

Reg. Dist. No. 23

1. PLACE OF DEATH:
County A. A. County
City or town Baltimore - 25
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yr.
Hospital, institution, or street address where death occurred:
Hammerlee Beach -
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County A.A. Co.
City or town 15 HAMMERLEE BEACH.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Franklin Schmuck

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W.	Widower

6.(b) Name of husband or wife Catherine J. Emmert
Feb. 16 1860 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 16 - 1860

8. AGE: Years	Months	Days	If less than one day
87		5	hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Clerk - Penn R.R.
11. Industry or business R. R. -

FATHER
12. Name Henry Schmuck
13. Birthplace Germany

MOTHER
14. Maiden name Mary Bohmer
15. Birthplace Germany

16. Informant HERMAN C STOLL
Address 15 HAMMERLEE BEACH AA Co.

17. BURIAL Date thereof 2 24 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory BALTIMORE
Location EAST END NORTH AVENUE

18. Funeral director JOHN F. DENNY, INC
Address 715 LIGHT ST.

19. 2/21 1947 C. W. Medrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1947, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13 1947 to Feb. 21 1947 and that I last saw him alive on Feb. 21 1947

Immediate cause of death	DURATION
Lobar Pneumonia	8 days
Due to	
Due to	
Other conditions Arteriosclerosis	15 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. L. Bare M.D.
M. D. or other
Address Limbrick Date signed 2-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-1

D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-6)

CERTIFICATE OF DEATH

[★] 01318

Reg. Dist. No. 23 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-44 15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 M. ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Patricia Lee Schools

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1946

8. AGE: Years	Months	Days	If less than one day
0	2	10	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: James Keith Schools
13. Birthplace: Glen Burnie, Md.

MOTHER
14. Maiden name: Hallie M. Yokum
15. Birthplace: Mud Camp, W. Va.

16. Informant: James K. Schools
Address: Glen Burnie, Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof Feb 13, 1947 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 2/13 (Date rec'd by registrar) 1947 Mae Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 12 1947, at 10 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post Mortem Examination 19..; and that I last saw h... alive on Feby. 13 1947

Immediate cause of death	DURATION
Due to: Influenza	
Due to: Meningitis	1 day
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Cafferty M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 2-13-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(846) 01319 260

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hsopital, Crownsville, Md.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1509 W. Mulberry
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edna Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Thomas Smith

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years	Months	Days	If less than one day
58	?	?	...hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ?

FATHER
12. Name: John Weston
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ida ?
15. Birthplace: Virginia

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb. 13, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore, Maryland

18. Funeral director: Katie R. Williams

Address: 322 N. Schroeder St. Baltimore, Md.

19. 2-12-47 (Date rec'd by registrar) 19... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1947, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5 1947 to February 10 1947 and that I last saw her alive on February 9 1947

Immediate cause of death	DURATION
	Known to us since 2/5/47
Due to	
Due to	
Other conditions: Catatonic excitement; stupor	Known to us since 2/5/47

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ida J. Schroeder M. D. or other

Address: Crownsville, Maryland Date signed: 2/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01320 8

(61) BC Reg. Dist. No. 280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: CROWNSVILLE STATE HOSPITAL, CROWNSVILLE, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? April 19, 1946
Hospital, institution, or street address where death occurred:
CROWNSVILLE STATE HOSPITAL, CROWNSVILLE, Md.
How long in hospital or institution? April 19, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 539 North Carey Street
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: SPRAGGINS, Bessie

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	married

6.(b) Name of husband or wife: Boston Spraggins Deceased
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 6 - 1885

8. AGE: Years: 62 | Months: - | Days: 27 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: no

FATHER
12. Name: Spencer Dawson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Marie - unknown
15. Birthplace: Virginia

16. Informant: Records of
Address: Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2 5 47 (month) (day) (year)
Cemetery or crematory: Woodlawn Memy Park
Location: Baltimore County Md

18. Funeral director: William A. Jackson
Address: 916 Pennsylvania ave

19. 2-4-47 (Date rec'd by registrar) 19____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2nd 1947 at 8. A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19- 1946 to February 2nd 1947 and that I last saw h[er] alive on Feb. 2nd 1947

Immediate cause of death: Coronary Occlusion — DURATION: 1 day

Due to: Arteriosclerosis, known to me since April 19- 1946

Due to: ____

Other conditions: Diabetes Mellitus, Senile Psychosis known to me since April 19- 1946
(Include pregnancy within 3 months of death)

Major findings of operation: Diabetic Gangrene left foot about 3 weeks

Date of op.: ____

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: ____ Date signed: ____

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

01321

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport, A. Co

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 518 Sixth Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 518 Sixth St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John B. Stevens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1891

8. AGE: Years	Months	Days	If less than one day
56		6	..... hrs. ..... min.

9. Birthplace: Calvert Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: James L. Stevens

13. Birthplace: Calvert Co. Md.

MOTHER — 14. Maiden name: Alice Worthington

15. Birthplace: Calvert Co. Md.

16. Informant: Mrs. Edward Podawsky

Address: Eastport A. A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-25-47 (month) (day) (year)

Cemetery or crematory: Edwards' Chapel

Location: Parole A A Co Md.

18. Funeral director: John M. Layton & Son

Address: Annapolis Md.

19. Feb 26, 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1947 at 4 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 24 3.45 pm 1947, to Feb 24 4 pm 1947

and that I last saw h... alive on Feb 24 1947

Immediate cause of death	DURATION
Coronary Thrombosis	15 Minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Basil M. D. or other

Address Annapolis Md Date signed 2-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

DATE, addr: dr's statement filmed G108 2-13-47 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

01322

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 910 (901) Poplar Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph Elliott Stevens

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife H. Mildred Stevens
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 19th 1893

8. AGE: Years 54 Months 0 Days 14 If less than one day hrs. min.

9. Birthplace A.A.Co. Maryland
(Town, county, and state)

10. Usual occupation Maternan P-W.R.R.

11. Industry or business Railroad

MOTHER FATHER
12. Name Joseph Stevens
13. Birthplace Calvert County Md.

MOTHER
14. Maiden name Mary Elliott
15. Birthplace Calvert County Md.

16. Informant H. Mildred Stevens
Address 910 Poplar Ave. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-47 (month) (day) (year)
Cemetery or crematory Glen Haven Cemetery
Location A.A. County Maryland

18. Funeral director John W. Taylor Son
Address 149 Gloucester St Annapolis Md.

19. Feb. 4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1947 at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Feb 1 1947
and that I last saw h= alive on Jan 30 1947

	DURATION
Immediate cause of death	
coronary occlusion	10 min
Due to arterio sclerotic cardio vascular disease & hypertension	10 yrs (?)
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Bozzuto MD
M. D. or other
Address Annapolis Md Date signed 2/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

★ 01323

Reg. Diat. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

93 Calvert Street

How long in hospital or institution? 56 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 93 Calvert Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Effie Stevenson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 31, 1896

8. AGE: Years	Months	Days	If less than one day
50	6	18	..... hrs. ..... min.

9. Birthplace: Annapolis Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: William Parker

13. Birthplace: Anne Arundel Co. Maryland

MOTHER

14. Maiden name: Eugenia Harris

15. Birthplace: Anne Arundel Co. Maryland

16. Informant: Georgia Price

Address: 43 Cathedral Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/21/1947 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. Feb 21 1947 (Date rec'd by registrar) M. Truitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 Feb 1947, at 4 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Jan 1947, to 18 Feb 1947

and that I last saw her alive on 18 Feb 47 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	2 hours
(Had hemiplegia, right, on 8 Feb 47	
Due to and b similar but more	
extensive episode occurred	
Due to 2 hours before death):	
Other conditions Prolapsed and gangrenous	2 mos
colostomy	

(Include pregnancy within 3 months of death)

Major findings of operations Temp. colostomy small bowel carcinoma in colostomy. Did not operate Date of op. 1 Feb 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Donald H. Harker M. D. or other

Address 53 Cornhill Annapolis, Md. Date signed 18 Feb 47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (103)

CERTIFICATE OF DEATH

01324

Reg. Diat. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Milton J. Stewart

3.(b) Social Security Number: 216-22-2545

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

B.(b) Name of husband or wife
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 5 - 1875

8. AGE:

Years	Months	Days	If less than one day
72	1	5	..... hrs. ..... min.

9. Birthplace: Near - Glen Burnie, A.A. Co.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Thomas D. Stewart
13. Birthplace: A.A. County, Md.

MOTHER
14. Maiden name: Lucy Ward
15. Birthplace: Carroll county, Md.

16. Informant: Mrs. Daisy L. Weyer,
Address: 747 Carroll St. Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 12, 1947 (month) (day) (year)
Cemetery or crematory: Stewarts Private
Location: Crain Highway, Near Glen Burnie Md.

18. Funeral director: Thomas W. Dugleton
Address: Glen Burnie, Md.

19. 2/12 (Date rec'd by registrar) 1947 M.R. Dealba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1947, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute circulatory disease	Sudden.
Due to: senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Gustave H. Fankenhus M. D. or other
Address: Glen Burnie, Md. Date signed: 2/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

01325

Reg. Diat. No. 201

NF

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Cumberstone
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Cumberstone
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Gloria Beatrice Tongue

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	Col	Single

6.(b) Name of husband or wife:
6.(c) If wife, give age ... years

7. Birth date of deceased (mo., day, yr.): May 27. 1946

8. AGE: Years 1 | Months 8 | Days 9 | If less than one day ... hrs. ... min.

9. Birthplace: Edgewater (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: Clinton Tongue
13. Birthplace: Hardesonville

MOTHER
14. Maiden name: Gloyne Magruder
15. Birthplace: Balto

16. Informant: Clinton Tongue
Address: Cumberstone Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7. 1947 (month) (day) (year)
Cemetery or crematory: Dan'l Star Cem.
Location: West River Md.

18. Funeral director: B. C. Standerfer & Son
Address: Galesville Md

19. 2/7/47 (Date rec'd by registrar) W. T. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6 1947 at 1.45 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Cardiorespiratory failure	
Due to: Congenital mal development	
Due to: Meningocele Ruptured	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward P. Ritchie M.D.
M.D. or other
Address: 1 & 2 Gloucester St Annapolis Md. Date signed: Feb. 6, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(950) 01326 8.

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Aa

City or town: North Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred: 548 Forrest View Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Aa Co

City or town: North Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. 548 Forrest View Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Harry Christopher Weigman

3. (b) Social Security Number: 216-01-1056

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband or~~ wife: Alice Marie Weigman

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Nov-11-1881

8. AGE:

Years	Months	Days	If less than one day
65	3	4	hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER 12. Name: Wm H. Weigman

FATHER 13. Birthplace: Baltimore Md.

MOTHER 14. Maiden name: Anna Marie Hoesner

MOTHER 15. Birthplace: Baltimore Md.

16. Informant: Alice M. Weigman

Address: 548 Forest View Rd, North Linthicum, Md

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 2/18/47 (month) (day) (year)

Cemetery or ~~crematory~~: St. Peters

Location: Balto. Md.

16. Funeral director: William Cook Inc.

Address: 1217 St. Paul St

19. 2/17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 1947, at 8:30 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-16- 1942, to 2-15- 1947 and that I last saw h. living alive on 2-10- 1947.

	DURATION
Immediate cause of death: Angina Pectoris	13½ months
Due to: Organic Heart Disease	Unknown
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chester Riland, M.D. M. D. or other

Address: 2532 Edmondson Ave. Date signed 2-15-47

Baltimore (23) Md

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★01327

Reg. Dist. No. 21

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HOWARD CRUETT WILCOX

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Etta Meseke
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Oct. 5, 1886

8. AGE: Years	Months	Days	If less than one day
60	4	9	hrs. min.

9. Birthplace: Catonsville, Md. (Town, county, and state)
10. Usual occupation: Lawyer
11. Industry or business

FATHER
12. Name: Howard R. Wilcox
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Elizabeth Paregoy (Peregoy)
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Howard C. Wilcox
Address: Severna Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18. Funeral director: Wm. Tickner & Sons
Address: North & Penna aves. Balto., Md.

19. 2-14 19 47 (Date rec'd by registrar) L. A. Blei Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February I4 19 47, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. I3 19 47 to Feb. I4 19 47 and that I last saw him alive on Feb. I3 19 47

Immediate cause of death	DURATION
Pulmonary edema	6 hrs.
Due to: Influenza	4 days
Due to:	
Other conditions: Paralysis agitans	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. A. Blei M.D. M. D. or other
Address: Pasadena, Md. Date signed: 2-14-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01328

Reg. Diat. No. 28?

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15 - 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 28 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 months 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1106 Stockton Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME
Henry Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Norma A. Williams

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years	Months	Days	If less than one day
53 ?	?	?	...hrs. ...min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ?

FATHER
12. Name: Wilson Williams
13. Birthplace: Georgia

MOTHER
14. Maiden name: Lula Laster
15. Birthplace: Georgia

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/22/47 (month) (day) (year)

Cemetery or crematory: Balto Nat.

Location: Baltimore City

18. Funeral director: Geo. G. Nelson

Address: 1303 Preston-an St.

19. 2-20-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 1947 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 1946 to February 18 1947 and that I last saw him alive on February 18 1947

Immediate cause of death: Massive Cerebral Hemorrhage — DURATION

Due to: General Paresis; Deteriorated Type — Known to us since 2/6/45

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01329

Reg. Dist. No. 211

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jacobsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Jacobsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 37 Fort Smallwood Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 17, 1866.

8. AGE: Years: 80 | Months: 10 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: England.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: General Farming

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Ida May Wilson
Address: Jacobsville, Pasadena P.O., Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-15-47 (month) (day) (year)
Cemetery or crematory: Holy Cross Cem. A.G.Co.
Location: Ritchie Highway

18. Funeral director: Fred G. Krohne & Son
Address: 1216 E. Chas. St.

19. 2-13 1947 L. A. Dees
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 13 1947, at 7-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem Examination, 19
~~and that I last saw him alive on~~ Feby. 13 1947

Immediate cause of death	DURATION
Second and third degree burns of	
entire body, right side	
Due to	due to heart attack
Other conditions	while lighting stove
in Kitchen.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

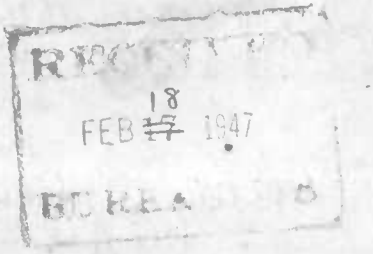
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Feby. 13, 1947
Where did injury occur? Jacobsville (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): at Home
Means of injury: clothing ignited Injured at work?

23. SIGNATURE: John M. Claffy, M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 2-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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